SAN ANTONIO SURGICAL ARTS
HEALTH HISTORY

Please answer all questions to the best of your abilities. Extra space is provided on the second page. Thank you.

Date:_______________ Name:____ ☐Male ☐Female

Height:______________ Weight:_____________ DOB:_______________________________________ Age:_________________

Tell us why you came to the doctor today. ____

____

Do you have mouth, face, head or neck pain? YES NO How long? ____

Where? ____

ALLERGIES TO:

1) Latex YES NO
2) Penicillin YES NO
3) Demerol, fentanyl, codeine hydrocodone, or other narcotics? YES NO
4) Novocaine, lidocaine, or other local anesthetics? YES NO
5) Please list any other medication allergies or other allergies:

____

HAVE YOU EVER:

1) Had any operations or surgery? YES NO Describe/list:____

____

2) Been admitted to a hospital? YES NO Describe:____
3) Had implanted joints, devices, plates, or screws? YES NO Describe:____

ILLNESSES:

Illness		
1) Eye problems	YES	NO
2) Glaucoma	YES	NO
3) Contact Lenses	YES	NO
4) Ear problems	YES	NO
5) Sinus trouble	YES	NO
6) Nasal obstruction	YES	NO
7) Dental problems	YES	NO
8) Heart trouble, CAD, or heart failure	YES	NO
9) Heart attack	YES	NO
10) Angina (chest pain)	YES	NO
11) Rheumatic fever	YES	NO
12) Heart murmur	YES	NO
13) Congenital heart disease	YES	NO
14) Heart surgery	YES	NO
15) Pacemaker	YES	NO
16) Heart stents	YES	NO
17) Abnormal heart beat	YES	NO
18) High blood pressure	YES	NO
19) Low blood pressure	YES	NO
20) High cholesterol or triglycerides	YES	NO
21) Shortness of breath	YES	NO
22) Lung problems	YES	NO
23) Emphysema	YES	NO
24) Asthma	YES	NO
25) Cough	YES	NO
26) GERD (acid reflux)	YES	NO
27) Ulcers	YES	NO
28) Liver disease	YES	NO
29) Hepatitis	YES	NO
30) Cirrhosis	YES	NO
31) Jaundice	YES	NO
32) Seizures or convulsions	YES	NO
33) Stroke or TIA	YES	NO
34) Anxiety	YES	NO
35) ADD/ADHD	YES	NO
36) Bipolar	YES	NO
37) Schizophrenic or schizoaffective	YES	NO
38) Prolonged bleeding	YES	NO
39) Frequent bruising	YES	NO
40) Frequent nosebleeds	YES	NO
41) Anemia	YES	NO
42) Dialysis	YES	NO
43) Kidney failure	YES	NO
44) Diabetes	YES	NO
45) Thyroid problems	YES	NO
46) Arthritis	YES	NO
47) Osteoporosis	YES	NO
48) Cancer or tumor	YES	NO
49) Radiation treatment (XRT)	YES	NO
50) Chemotherapy	YES	NO

ADDITIONAL QUESTIONS

1) If you have asthma, have you ever been treated in an ER, urgent care, or hospital for your asthma? YES NO N/A
2) If you have had cancer or a tumor, what kind was it? When was it?____________________________________

____
3) Do you have "TMJ", "TMD", clicking or popping of jaw joint, pain near the ear, or difficulty opening your mouth? YES NO
4) Do you grind or clench your teeth? YES NO
5) Do you smoke or use smokeless tobacco? If so, how much? YES NO
6) Do you drink alcohol? If so, how much? YES NO
7) Do you use marijuana, cocaine, or other "recreational" drugs? Which ones?__________________ YES NO
8) Do you have any history of alcohol or chemical dependency? YES NO
9) Are you on a special diet? Describe YES NO
10) Have you ever had anesthesia or sedation? YES NO
11) Have you or your immediate family had any problems with anesthesia or sedation? YES NO

Describe:____

12) Is there any reason to believe you may be immunosuppressed? Describe YES NO
13) Do you have any autoimmune diseases (rheumatoid arthritis, lupus, Chrohn's, ulcerative colitis, psoriasis, etc)? YES NO

WOMEN ONLY

1) Are you pregnant, or is there ANY chance you may be pregnant? YES NO
2) Are you on birth control? What kind? YES NO
3) Are you breast feeding? YES NO
4) Date of your last menstrual cycle? _________________________ ☐N/A

MEDICATIONS

1) Do you take blood thinners such as aspirin, ASA, Plavix, clopidogrel, warfarin, Coumadin, Xarelto, rivaroxaban, Pradax, dabigatiran, Aggrenox, dipyridamole, Ticlid, ticlopidine, heparin, Lovenox, Eliquis, apixaban, or others? YES NO
2) Have you taken steroids within the last 3 months? YES NO
3) Have you ever taken bisphosphonates (Boniva, Fosamax, Actonel, Aredia, Zometa, Reclast, alendronate)? YES NO
4) Have you ever taken denosumab, Prolia, or Xgeva? YES NO
5) Have you ever taken bevacizumab or Avastin? YES NO
6) Do you take immunosuppressive drugs such as methotrexate, Plaquenil, Orencia, Remicade, Enbrel, or Humira? YES NO
7) Have you been told NOT to take NSAIDs, Tylenol, acetaminophen, Advil, ibuprofen, Aleve or similar drugs? YES NO

LIST ALL MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING

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PLEASE LIST ANY ADDITIONAL ILLNESSES, COMMENTS, OR INFORMATION WE NEED TO KNOW

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I understand the importance of a truthful and complete Health History and realize that my incomplete information may have an adverse effect on my treatment. To the best of my knowledge, the information provided is complete and accurate.

Signature ____ Date ___________________________

Print name and relationship if you are not the patient____

Reviewed by ____ (doctor) Date ___________________________